Application Checklist for Speech-Language Pathology Aide

1. Application

2. Registration Fee

- Check or Money Order to Board for $10

3. Fingerprints

- If a California resident, must do Livescan; send copy of your form to the Board. Fees paid directly to Livescan Operator.

STATE OF CALIFORNIA
DEPARTMENT OF CONSUMER AFFAIRS

STATE AND CONSUMER SERVICES AGENCY • GOVERNOR EDMUND G. BROWN JR.
SPEECH-LANGUAGE PATHOLOGY & AUDIOLOGY & HEARING AID DISPENSERS BOARD
2005 EVERGREEN STREET, SUITE 2100, SACRAMENTO, CA 95815
PHONE (916) 263-2666 FAX (916) 263-2668 www.speechandhearing.ca.gov

REGISTRATION OF SPEECH-LANGUAGE PATHOLOGY OR AUDIOLOGY AIDE

1. NAME OF LICENSED SPEECH-LANGUAGE PATHOLOGIST OR AUDIOLOGIST WHO WILL BE SUPERVISING THE AIDE:

LAST FIRST MIDDLE LICENSE NUMBER

NAME OF BUSINESS

BUSINESS STREET ADDRESS

CITY STATE ZIP CODE BUSINESS PHONE NUMBER

THE FOLLOWING AIDES ARE APPROVED BY THE BOARD TO WORK UNDER MY SUPERVISION:

2. NAME OF AIDE

LAST FIRST MIDDLE BEGINNING DATE OF EMPLOYMENT AS AIDE

HOME ADDRESS HOME PHONE NUMBER

CITY STATE ZIP CODE

SOCIAL SECURITY NUMBER DATE OF BIRTH

A supervisor of a speech-language pathology or audiology aide shall:

(a) Have legal responsibility for the health, safety and welfare of the patients.

(b) Have legal responsibility for the acts and services provided by the speech-language pathology or audiology aide, including compliance with the provision of the Act and these regulations.

(c) Be physically present while the speech-language pathology or audiology aide is assisting with patients, unless the board has approved an alternative plan of supervision. A supervisor of industrial audiology aides shall include a proposed plan for alternative supervision with the registration form. An industrial audiology aide may only be authorized to conduct air conduction threshold audiograms when performing outside the physical presence of a supervisor. The supervisor shall review all patients' histories and the audiograms and make any necessary referrals for evaluation and treatment.

(d) Evaluate, treat, manage and determine the future disposition of patients.

(e) Appropriately train the speech-language pathology or audiology aide to perform duties to effectively assist in evaluation and/or treatment. A supervisor shall establish and complete a training program for speech-language pathology or audiology aides in accordance with Section 1399.154.4 which is unique to the duties of the aide and the setting in which he or she will be assisting the supervisor.

(f) Define the services which may be provided by the speech-language pathology or audiology aide. These services shall not exceed the competency of the aide as determined by his or her education, training and experience, and shall not include any treatment beyond the plan established by the supervisor for the patient.

WE HEREBY CERTIFY UNDER PENALTY OF PERJURY UNDER THE LAWS OF THE STATE OF CALIFORNIA THAT ALL STATEMENTS MADE HEREIN ARE TRUE IN EVERY RESPECT, AND THAT MISSTATEMENTS OR OMISSIONS OF MATERIAL FACTS MAY BE CAUSE FOR DENIAL OF THIS REGISTRATION, OR FOR SUSPENSION OR REVOCATION OF A LICENSE.

SIGNATURE OF SUPERVISOR (IN BLUE INK) DATE SIGNATURE OF AIDE (IN BLUE INK)

Filing Fee $10.00. Make check payable to SLPAHADB

A. List all duties the aide will perform in assisting the supervisor/licensee in the practice of speech-language pathology or audiology. For each duty listed, describe the method of supervision. **Be specific.**

1.

2.

3.

4.

B. For each duty listed in "A" above, describe in detail the supervisor's training methods, the necessary minimum competency level of the aide, the manner in which the aide's competency will be assessed, the persons responsible for the training, a summary of any past education, training and experience the aide may have already undertaken, the length of the training program, and assessment of the aides, competency level. Include a copy of any training manuals to be used.

1.

2.

3.

4.

INFORMATION COLLECTION AND ACCESS

The Speech-Language Pathology and Audiology Board's Executive Officer is the person who is responsible for information maintenance. Section 2532 of the Business and Professions Code is the authority, which authorizes the maintenance of the information. All information is mandatory. Failure to provide any mandatory information will result in the application being rejected as incomplete. The information provided will be used to determine qualification for licensure. Each individual has the right to review his or her file maintained by the agency subject to the provisions of the California Public Records Act.

SOCIAL SECURITY DISCLOSURE NOTICE

Disclosure of your Social Security Number (SSN) is mandatory. Section 30 of the Business and Professions Code and Public Law 94-455 (42 USCA 405 (c) (2) C)) authorize collection of your SSN. Your SSN will be used exclusively for tax enforcement purposes, for purposes of compliance with any judgment or order for family support in accordance with Section 11350.6 of the Welfare and Institutions Code, or for verification of licensure or examination status by a licensing or examination entity which utilizes a national examination and where licensure is reciprocal with the requesting state. If you fail to disclose your SSN, you will be reported to the Franchise Tax Board, which may assess a $100 penalty against you.

REQUEST FOR LIVE SCAN SERVICE

Applicant Submission

ORI: A0437 (Code assigned by DOJ) Type of Application: (check one) ___ Employment X License, Certification, Permit ___ Volunteer

Job Title or Type of License, Certification or Permit: Speech Pathologist Audiologist Speech Assistant Aide

PLEASE CIRCLE ONE

Agency Address Set Contributing Agency:

SPEECH-LANGUAGE PATHOLOGY & AUDIOLOGY & HEARING AID DISPENSERS BOARD
Agency authorized to receive criminal history information

06187
Mail Code (five-digit code assigned by DOJ)

2005 Evergreen Street, Suite 2100
Street No. Street or PO Box

N/A
Contact Name (Mandatory for all school submissions)

Sacramento CA 95815
City State Zip Code

( )
Contact Telephone No.

Name of Applicant: _____
(Please print) Last First MI

AKA's: _____
Last First

CDL No. _____

DOB: _____ SEX: ___ Male ___ Female

Misc. No. **BIL -** Applicant Must Pay At Site
Agency Billing Number (if applicable)

HT: _____ WT: _____

Misc. No. _____

EYE Color: _____ HAIR Color: _____

Home Address: (Applies only if Youth Org/HRA or Public Utility submission)

POB: _____

Street or PO Box

SOC: _____

City, State and Zip Code

Your Number: 7700 SLP/AU
OCA No. (Agency Identifying No.)

Level of Service DOJ X FBI X

If resubmission, list Original ATI No. _____

Employer: (Additional response for Department of Social Services, DMV/CHP licensing, and Department of Corporations submissions only)

THIS SECTION IS NOT APPLICABLE
Employer Name

Street No. Street or PO Box

Mail Code (five digit code assigned by DOJ)

City State Zip Code

( )
Agency Telephone No. (Optional)

Live Scan Transaction Completed By: _____
Name of Operator

Date _____

Transmitting Agency

ATI No.

Amount Collected/Billed

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Name of Operator

Transmitting Agency ATI No. Amount Collected/Billed

BCII 8016 (Rev10/98) **ORIGINAL-Live Scan Operator; SECOND COPY-Requesting Agency; THIRD COPY-Applicant**